

## Mental Retardation Community Medicaid Services

\_\_\_\_ NEW  
FOR CSP YEAR

\_\_\_\_ REVISION  
FOR CSP YEAR

**Consumer-Directed  
Companion Services  
INDIVIDUAL SERVICE PLAN**

Individual: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Services Facilitator/Agency: \_\_\_\_\_ SF Provider Number: \_\_\_\_\_

Services Facilitator Telephone Number: \_\_\_\_\_ Services Facilitation Start Date: \_\_\_\_\_

Designated Backup: \_\_\_\_\_ Telephone: \_\_\_\_\_

ISP Start Date: \_\_\_\_\_ Quarterly Review Dates: \_\_\_\_\_

SUPPORT GOAL/OUTCOME: *To be as independent as possible in my home and community.*

PURPOSE OF SUPPORT <i>(Examples in italics.)</i>	WHEN SUPPORT IS PROVIDED	WHERE AND HOW SUPPORT WILL BE PROVIDED <i>(Examples in italics.)</i>

--	--	--